STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **155199**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C **11/10/2011**

NAME OF PROVIDER OR SUPPLIER **MAPLE PARK VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **776 N UNION ST** **WESTFIELD, IN 46074**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00098969. Complaint IN0009869- Unsubstantiated due to lack of evidence. Survey dates: November 9 & 10, 2011 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Survey team: Christi Davidson, RN-TC Census bed type: SNF: 8 NF: 72 Total: 80 Census payor type: Medicare: 7 Medicaid: 48 Other: 25 Total: 80 Sample: 3 Maple Park Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00098969. Quality review completed 11/14/11 by Jennie Bartelt, RN.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE